

**ACGME COMMON PROGRAM REQUIREMENTS – SECTION VI
COMPILATION OF PUBLIC COMMENTS**

Received letters of support or letter with no comments from the following:

- Associate Director, Family Medicine
- Associate Professor, Orthopaedic Surgery
- Chief Resident, Family Medicine
- Education Program Coordinator, Gastroenterology and Transplant Hepatology
- Program Director, Orthopaedic Surgery

Comments received from the following:

Organizations and Specialty Societies

- Specialty Program Directors Association (2)
- Specialty Board
- Specialty College
- Specialty Society
- National Medical Organization

Other

- Program Director, Family Medicine (5)
- Program Director, General Surgery (4)
- Designated Institutional Official (3)
- Program Director, Obstetrics and Gynecology (3)
- Director, Graduate Medical Education (2)
- Program Director, Internal Medicine (2)
- Accreditation Administrator
- Accreditation Manager
- Associate Dean for Graduate Medical Education
- Associate Professor, Division of Cardiothoracic Surgery
- Associate Professor of Surgery (Urology)
- Associate Program Director, Orthopaedic Surgery
- Associate Program Director, Surgery
- Chief, Division of Plastic and Reconstructive Surgery
- Chief, Section of Pediatric Cardiothoracic Surgery
- Chief, Section of Thoracic Surgery
- Education Program Manager
- Owner, Medical Billing Company
- PGY-1 Resident, Family Medicine
- Professor of Colon and Rectal Surgery
- Professor of Surgery
- Professor of Surgery and Radiology
- Program Director, Cardiology Fellowship
- Program Director, Critical Care
- Program Director, Dermatology
- Program Director, Hematology/Oncology Fellowship
- Program Director, Neurology
- Program Director, Ophthalmology

- Program Director, Orthopaedic Surgery
- Program Director, Otolaryngology
- Program Director, Pathology
- Program Director, Pediatrics
- Program Director, Pediatric Anesthesiology Fellowship
- Program Director, Pediatric Cardiology Fellowship
- Program Director, Radiology
- Program Director, Rheumatology Fellowship
- Program Director, Vascular Surgery
- [Specialty and position unknown] (1)

Requirement #: VI. – VI.A.3.

Requirement Language:

VI. Resident Duty Hours in the Learning and Working Environment

VI.A. Professionalism, Personal Responsibility, and Patient Safety

VI.A.1. Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients. (Core)

VI.A.2. The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment. (Core)

VI.A.3. The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs. (Core)

List Individual Comment(s):

Section VI.A. (Professionalism, Personal Responsibility, and Patient Safety): add specific requirements regarding the monitoring of errors and near misses.

-Specialty Program Directors Association

VI.A.1. - Is it the responsibility of programs and sponsoring institutions to “educate faculty members concerning professional responsibilities” etc..? Resident yes, but I don’t believe that educating faculty members on the professional responsibilities of a physician falls to the programs. Faculty members should know this already-shouldn’t they?

-Director, Graduate Medical Education

As an educator in a GME office, one challenge in providing program support is not always being certain what is required. I would appreciate greater clarity in terms of the following requirements:

- VI.A.3. The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.
 - o What is meant by “programs”? Projects? Didactics? Committees? Activities?

-Education Program Manager

Section VI.A.3. Most of the GME community are still trying to figure out what this one means. It would be helpful if it gave parameters, e.g. participation on a committee or completion of a project.

-Accreditation Administrator

[The Specialty Board] commends the ACGME for the emphasis placed on professionalism and patient safety in the Common Program Requirements. By doing so, the importance of personal responsibility and fitness for duty is at the forefront in resident education. Training programs now instruct the resident as to how to manage time before, during, and after clinical assignments, and such education will help prepare residents for time management throughout their careers. It is important to stress that patients entrust their care with us as physicians, and that how residents use their time outside of residency has a direct effect on the care that is provided.

Highlighting that the program must not compromise resident education by excessive reliance on residents for non-physician service obligations has enabled residency leadership to require institutional support for clinical duties that do not enhance education. Previously, this burden fell solely on the core faculty to develop a solution to excess service needs over which they had little control.

-Specialty Board

The AMA Council on Medical Education is pleased to provide the following information regarding [our] policies related to the Task Force's request.

Fostering Professionalism During Medical School and Residency Training (D-295.983) calls on our AMA, in consultation with other relevant medical organizations and associations, to work to develop a framework for fostering professionalism during medical school and residency training.

This planning effort should include the following elements:

- a) Synthesize existing goals and outcomes for professionalism into a practice-based educational framework, such as provided by the AMA's Principles of Medical Ethics.
- b) Examine and suggest revisions to the content of the medical curriculum, based on the desired goals and outcomes for teaching professionalism.
- c) Identify methods for teaching professionalism and those changes in the educational environment, including the use of role models and mentoring, which would support trainees' acquisition of professionalism.
- d) Create means to incorporate ongoing collection of feedback from trainees about factors that support and inhibit their development of professionalism. This policy also states that our AMA, along with other interested groups, will continue to study the clinical training environment to identify the best methods and practices used by medical schools and residency programs to fostering the development of professionalism.

The AMA Duty Hours Policy (H-310.907) states that our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of duty hours, including development of professionalism; that accurate, honest, and complete reporting of resident duty hours is an essential element of medical professionalism and ethics; and that the medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education.

Alignment of Accreditation Across the Medical Continuum (H-295.862) states that our AMA supports the concept that evaluation of physicians as they progress along the medical education continuum should include the following: (a) assessments of each of the six competency

domains of patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice.

Medicolegal, Political, Ethical and Economic Medical School Course (H-295.961) states that there should be attention to subject matter related to ethics and to the doctor-patient relationship at all levels of medical education: undergraduate, graduate, and continuing. Role modeling should be a key element in helping medical students and resident physicians to develop and maintain professionalism and high ethical standards.

To conclude, the Council believes that the ACGME's plan to consider revisions to Section VI of the Common Program Requirements is prudent, especially in light of early results from the Flexibility in Duty Hour Requirements for Surgical Trainees (FIRST) trial. Attention to these results, and ongoing research in this area, contribute to the medical education community's perception that the Common Program Requirements comprise what is necessarily a living document, nimble enough to accommodate changing training needs and environments.

-National Medical Organization

Requirement #: VI.A.4. – VI.A.4.b)

Requirement Language:

VI.A.4. The learning objectives of the program must:

VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and, (Core)

VI.A.4.b) not be compromised by excessive reliance on residents to fulfill non-physician service obligations. (Core)

List Individual Comment(s):

VI.A.4.b) This should be fleshed out with greater detail as currently subjected to interpretation. Particularly as this is an ACGME Survey question.

-Associate Dean for Graduate Medical Education

Requirement #: VI.A.6. – VI.A.6.h)

Requirement Language:

VI.A.6. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

VI.A.6.a) assurance of the safety and welfare of patients entrusted to their care; (Outcome)

VI.A.6.b) provision of patient- and family-centered care; (Outcome)

VI.A.6.c) assurance of their fitness for duty; (Outcome)

VI.A.6.d) management of their time before, during, and after clinical assignments; (Outcome)

VI.A.6.e)	recognition of impairment, including illness and fatigue, in themselves and in their peers; (Outcome)
VI.A.6.f)	attention to lifelong learning; (Outcome)
VI.A.6.g)	the monitoring of their patient care performance improvement indicators; and, (Outcome)
VI.A.6.h)	honest and accurate reporting of duty hours, patient outcomes, and clinical experience data. (Outcome)

List Individual Comment(s):

I have only one comment on Section VI. Specifically Section VI.A.6.d.

This is in reference to residents' personal time outside of hospital hours and assigned duties. As stated, it says that we are responsible for monitoring their activities outside the hospital and work environment to ensure they are safe, rested, etc.

I'm not sure who wrote that, but it is not the responsibility of a program director to tell an adult how to spend his or her free time outside the program, nor is it my responsibility to babysit them to see that they take care of themselves and sleep enough. You cannot make us legally responsible for their actions when they are outside of the work environment.

That is just absurd. If we see performance issues, or identify sleep deprivation, or personality change, we can address it and try to find the root cause, but the ACGME cannot require me to monitor their activity outside of work. This is a human rights violation. No one can tell them what to do outside of work. All you can do is set up programs for them to attend as support if they are getting into trouble or having problems

This entire section needs to be removed.

-Program Director, Vascular Surgery

VI.A.6.d) Does this need to be better defined? Is this too subjective?

VI.A.6.g) How? I think this goes back to the ACGME Survey question around clinical effectiveness. Where is the data to help them monitor their performance?

-Director, Graduate Medical Education

As an educator in a GME office, one challenge in providing program support is not always being certain what is required. I would appreciate greater clarity in terms of the following requirements:

- VI.A.6.g) Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following...the monitoring of their patient care performance improvement indicators.
 - o Perhaps this could be changed to something along the lines of faculty and residents must analyze patient care data for the purpose of practice improvement.
 - o It would also help to make clear whether it needs to be their own patient data or whether division/section/department data is acceptable.

-Education Program Manager

Suggested addition: VI A 6 i) self-monitoring of physician wellness, and their responsibility to identify system problems, including but not limited to no-added-value administrative burdens that negatively impact physician wellness. In addition, the program must have in place a method to address resident concerns related to system problems affecting physician wellness.

-Program Director, Rheumatology Fellowship

Requirement #: VI.A.7.

Requirement Language:

VI.A.7. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. They must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. (Outcome)

List Individual Comment(s):

VI.A.7. - Is the responsibility of the programs to ensure faculty members recognize what the best interests of the patient are? Isn't that why they are faculty-because they have the maturity and experience to recognize this?

-Director, Graduate Medical Education

It would seem that **recognizing** isn't the only part; there should probably also be explicit mechanisms in place for this to happen.

-Associate Dean for Graduate Medical Education

Requirement #: VI.B. – VI.B.4.

Requirement Language:

VI.B. Transitions of Care

VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care. (Core)

VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)

VI.B.3. Programs must ensure that residents are competent in communicating with team members in the hand-over process. (Outcome)

VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care. (Detail)

List Individual Comment(s):

There is an inherent tension between VI.B.1, regarding the need to minimize transitions in patient care, and the work hour rules outlined in section VI.G: The need to minimize work hours has resulted in more frequent transitions of care. In fact, there may be up to three to four transitions of care in a twenty-four period for one patient due to the work hour restrictions.

It is still not clear that work hour restrictions result in better patient care. It certainly results in discontinuous care and impacts the residents' ability to follow a patient closely during the course of the patient's care.

-Director, Hematology/Oncology Fellowship

Given the nature of shift work in [our specialty], [the Specialty Board] is keenly aware of how transitions of care affect patient safety if such transition is not performed using a structured process. Many innovative solutions have been developed that are used by [specialty] residents to convey pertinent information in an efficient manner during shift change as a result of the

inclusion of transitions of care in the Common Program Requirements. In many cases, these processes have highlighted existing capabilities of Electronic Medical Records that previously had gone underutilized. [Our specialty] has always recognized the patient risk issues and the liability associated with the hand-off process, but by placing transitions of care prominently in the Common Program Requirements, education and assessment of competency is now mandatory, which will facilitate all residents' understanding of the hand-off process as it relates to patient safety.

-Specialty Board

Requirement #: VI.C. – VI.C.1.c)

Requirement Language:

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. The program must:

VI.C.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation; (Core)

VI.C.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and, (Core)

VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules. (Detail)

List Individual Comment(s):

Section VI.C.1-1.b) It would be helpful if the requirement gave a bit more guidance on how often the fatigue related training should be done, e.g. annually or biannually.

-Accreditation Administrator

Section VI.C (Alertness Management/Fatigue Mitigation):

- Require documentation of all episodes when (a) fatigue mitigation processes are activated (VI.C.1.c) or (b) the process to ensure continuity of care when a resident is unable to perform his/her duties due to fatigue is utilized (VI.C.2).
- Establish a clearly delineated process for how programs will assess residents post call for signs of fatigue that are severe enough that the resident is not fit to remain in house post call (see our recommendations below to section VI.G.4.b).

-Specialty Program Directors Association

[Our specialty] schedules traditionally have always allowed for sufficient time off between shifts to help mitigate resident fatigue. The additional requirement that all programs must have processes in place to ensure continuity of care in the event of resident fatigue has helped residents overall on their rotations outside of the [department]. A greater emphasis has been noted in institutions to allow additional providers to offset the workload of any one resident that noticeably has mitigated fatigue from caring for too many patients at one time. Continued deepened education in physician wellness will likely result in improved career satisfaction and have a direct impact on patient safety.

-Specialty Board

VI.C.1.a). Add emotional or psychological impairment to list of symptoms to recognize.
VI.C.1.c). Add counseling or therapy as tools to manage symptoms of impairment. This would only be necessary if the above recommendation to VI.C.1.a) is implemented, of course.

-Owner, Medical Billing Company

The AMA Council on Medical Education is pleased to provide the following information regarding [our] policies related to the Task Force's request.

Physician Health and Wellness (D-405.992) calls on our AMA to:

- (1) Support programs related to physician health and wellness, including those offered in conjunction with the Federation of State Physician Health Programs;
- (2) Convene those interested in medical education in an effort to bring the dialogue about healthy lifestyle and balance early in the careers of medical students and residents; and
- (3) Consider the concept of physician wellness as an element of the AMA Strategic Plan.

Educating Physicians About Physician Health Programs (D-405.990) states that:

- 1) Our AMA will work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory;
- 2) Our AMA will continue to collaborate with relevant organizations on activities that address physician health and wellness;
- 3) Our AMA will, in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs; and
- 4) Our AMA will work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training.

Physician Well-Being and Renewal (D-405.996) states that our AMA will work with the Federation of State Physician Health Programs to establish and promulgate a networking resource/database and web site clearinghouse for Medical Staff Physician Health Committees or their equivalents in physician groups throughout the country, and to provide resources that will allow such committees to proactively initiate programs of wellness and illness prevention for physicians.

Physician Health Programs (H-405.961) asserts that our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness.

Physicians and Physicians-in-Training as Examples for Their Patients to Promote Wellness and Healthy Lifestyles (H-405.959) calls on our AMA to establish a program that recognizes physicians and physicians-in-training who model wellness and healthy lifestyles in their practice and communities or establish programs that contribute to the wellness of their patients and/or community; and aid in the development of a health and wellness component in conjunction with the Doctors Back to School Program.

To conclude, the Council believes that the ACGME's plan to consider revisions to Section VI of the Common Program Requirements is prudent, especially in light of early results from the Flexibility in Duty Hour Requirements for Surgical Trainees (FIRST) trial. Attention to these results, and ongoing research in this area, contribute to the medical education community's perception that the Common Program Requirements comprise what is necessarily a living document, nimble enough to accommodate changing training needs and environments.

-National Medical Organization

Requirement #: VI.D.2.

Requirement Language:

VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients. (Core)

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care. (Detail)

List Individual Comment(s):

Provide more clear documentation of supervision, including the availability of call schedules for review demonstrating which faculty are supervising each trainee (section VI.D.2).

-Specialty Program Directors Association

The AMA Council on Medical Education is pleased to provide the following information regarding [our] policies related to the Task Force's request.

Resident Physician Working Hours and Supervision (H-310.979) states that:

1. Our AMA supports the following principles regarding the supervision of residents and the avoidance of the harmful effects of excessive fatigue and stress:
 - a) Exemplary patient care is a vital component for any program of graduate medical education. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited residency program. Graduate medical education must never compromise the quality of patient care.
 - b) Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.
 - c) Institutional commitment to graduate medical education must be evidenced by compliance with Section III.B.4 of the ACGME Institutional Requirements, effective July 1, 2007: The sponsoring institution's GME Committee must [m]onitor programs' supervision of residents and ensure that supervision is consistent with: (i) Provision of safe and effective patient care; (ii) Educational needs of residents; (iii) Progressive responsibility appropriate to residents' level of education, competence, and experience;
 - d) The program director must be responsible for the evaluation of the progress of each resident and for the level of responsibility for the care of patients that may be safely delegated to the resident.
 - e) Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.

- f) The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with Residency Review Committee (RRC) recommendations, and in compliance with the ACGME duty hour standards.
- g) The program director, with institutional support, must assure for each resident effective counseling as stated in Section II.D.4.k of the Institutional requirements: "Counseling services: The Sponsoring Institution should facilitate residents' access to confidential counseling, medical, and psychological support services."
- h) As stated in the ACGME Institutional Requirements (II.F.2.a-c), "The Sponsoring Institution must provide services and develop health care delivery systems to minimize residents' work that is extraneous to their GME programs' educational goals and objectives." These include patient support services, laboratory/pathology/radiology services, and medical records.
- i) Is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents. As stated in the ACGME Common Program Requirements (VI.B) "the program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities."
- j) Individual resident compensation and benefits must not be compromised or decreased as a result of these recommended changes in the graduate medical education system.

2. These problems should be addressed within the present system of graduate medical education, without regulation by agencies of government.

While the previous AMA policy was last modified in 2008, and items c, g, h and i therefore do not reflect the exact language of the current set of Common Program or Institutional Requirements (effective 2015), the intent of these items is broadly equivalent to sections IV.A.4 and VI.D.2 in the current Common Program Requirements and sections II.F.1, and IV.H.1, and IV.I of the current Institutional Program Requirements.

Section 12 in the Principles for Graduate Medical Education (H-310.929), Supervision of Resident Physicians, states that program directors must supervise the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows.

To conclude, the Council believes that the ACGME's plan to consider revisions to Section VI of the Common Program Requirements is prudent, especially in light of early results from the Flexibility in Duty Hour Requirements for Surgical Trainees (FIRST) trial. Attention to these results, and ongoing research in this area, contribute to the medical education community's perception that the Common Program Requirements comprise what is necessarily a living document, nimble enough to accommodate changing training needs and environments.

-National Medical Organization

Requirement #: VI.D.3. – VI.D.3.c)

Requirement Language:

VI.D.3. Levels of Supervision

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision: (Core)

- VI.D.3.a) Direct Supervision – the supervising physician is physically present with the resident and patient. (Core)
- VI.D.3.b) Indirect Supervision:
- VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. (Core)
- VI.D.3.b).(2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision. (Core)
- VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)

List Individual Comment(s):

Provide examples of oversight (section VI.D.3.c) similar to how we will request documentation of episodes of when the fatigue management process is activated.

-Specialty Program Directors Association

The Program Directors Section feels that first-year residents should be permitted to progress to indirect supervision with direct supervision available (as opposed to immediately available), according to their individual levels of achievement. The ACGME acknowledges that residents progress at different rates according to their individual backgrounds, abilities and curricula, which is why the milestones are not tied to levels of training. Thus a resident in an AP-only or CP-only training track is likely to progress more quickly in his/her focused areas than a resident in an AP/CP track in a program that mixes AP and CP in the first year of training. To base graduated responsibility on time rather than on achievement goes against the fundamental concept of milestone-based training and deprives some pathology residents of opportunities for appropriate graduated responsibility within the first year of their residency.

-Specialty Program Directors Association

Requirement #: VI.D.4. – VI.D.4.c)

Requirement Language:

- VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)
- VI.D.4.a) The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific

	national standards-based criteria. (Core)
VI.D.4.b)	Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents. (Detail)
VI.D.4.c)	Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)
List Individual Comment(s):	
VI.D.4.a) Isn't this uniformly available now with reporting milestones?	
-Associate Dean for Graduate Medical Education	

Requirement #: VI.D.5. – VI.D.5.a).(1)	
Requirement Language:	
VI.D.5.	Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions. (Core)
VI.D.5.a)	Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence. (Outcome)
VI.D.5.a).(1)	In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. [Each Review Committee will describe the achieved competencies under which PGY-1 residents progress to be supervised indirectly, with direct supervision available.] (Core)
List Individual Comment(s):	
VI.D.5.a).(1) The arbitrary use of 1 year of training is not appropriate for all specialties with all types of care. Certainly when doing procedures this supervision makes sense. Some of our interns have more than 80 deliveries before the end of their first year and frankly can see and triage patients safely because they know their limits without needing an attending in house to assure that they are doing a good job. I would propose that each specialty define what milestones or competencies need to be achieved prior to moving from indirect supervision immediately available to indirect available supervision so that an appropriate intern could be advanced whereas a behind second year or a certain patient type may be OK but procedures are not. This should be RRC dependent rather than generic as it is using an axe where a scalpel would be better.	
-Program Director, Family Medicine	
[Our specialty] is one of only a few specialties in which all patient encounters that involve residents are directly supervised by an attending physician. The significance added in the Common Program Requirements has enhanced the education that our residents acquire on off-service rotations to a significant degree. Direct supervision that is mandated during the PGY-1 year has greatly enriched the learning by [specialty] residents as the one-on-one guidance that is provided in the department extends throughout the hospital. Trainees are able to discuss	

cases with an attending physician, which undoubtedly augments the learning environment, rather than receiving instruction only by a more senior resident.

The Common Program Requirements on supervision do not distinguish the point at which supervision, and thereby the responsibility of care, transfer to a non-[specialty] resident (and the respective attending) who is functioning either as a consultant in the [department], or in the hospital, caring for an admitted patient. Frequently, the department attending physician may be the only attending physician available in-person to oversee services provided by non-[specialty] residents, acting as consultants in the department, such as an orthopedic resident performing a hip reduction, or a plastic surgery resident repairing a complicated cosmetic laceration. Circumstances arise where the [department] attending physician may not have privileges in a given area in which he or she is the only attending physician available, in the event of a question or immediate complication. The Common Program Requirements should be modified to include a provision that direct supervision by an additional supervising attending, such as a consultant or admitting attending physician, must be provided in the event that the scope of care of the patient lies outside of the hospital privileges of the [specialty] physician.

Similarly, the department attending physician may be the only supervising physician to have directly cared for the patient for a period of up to 24 hours, depending on the time of day that the patient presented to the [department]. While there is indirect supervision always available on the off-service rotations, a greater emphasis could be placed in the Common Program Requirements as to the maximum length of time that could pass without direct supervision being provided on the care of any given patient. Director supervision requirements should include an attending (faculty) physician seeing the patient within an explicitly defined and limited period.

-Specialty Board

VI.D.5.a).(1) PGY-1 residents should be supervised directly or indirectly with direct supervision immediately available.

– There is no provision to allow a PGY-1 resident to advance to indirect supervision with direct supervision available, yet medical students routinely function at this level. While a medical student cannot give an order for patient care, a PGY-1 resident in the electronic world of care can and do give orders from wherever they happen to be –home, office, library, local restaurant with WiFi. There is no way to have a physician immediately available in every setting in which they might enter an order for patient care. So, they are actually caring for patients remotely without direct supervision immediately available. To restrict their time in the hospital or office to only when a senior resident or faculty is ‘in the building’ adds no measure of safety when we have electronic order entry. In fact, a nurse can (and do) call them directly and get verbal or computer orders that a physician in the building would have no way of knowing. There is no additional patient safety added by requiring a senior resident or faculty to be in the same building. In a large academic center, it is a relatively easy thing to ensure some senior resident from one of the many programs is in the hospital at all times. In a single residency program, and particularly with two affiliated hospitals, it is a laborious restriction that delays patient care and diminishes the PGY-1 resident compared to medical students. We routinely send a medical student to our second hospital to begin a patient evaluation while the residents finish work at the first hospital. It would be better care to send the PGY-1 resident to begin to evaluate the patient, but they can’t go to the other hospital until their supervising resident can also go with them. It really impedes care while adding no increase in safety. In fact, the residents are often in the position of entering initial orders based on the lab findings and ER doc reports without seeing the patient, because supervision of care can’t be provided in two hospitals at the same time. PGY-1 residents that meet criteria should be able to advance to indirect supervision with direct supervision available. The immediate standard is too restrictive. Finally, it makes no sense that

on day 366, a resident can jump to that higher standard and in fact begin to do the supervision of PGY-1 residents, but never practice without supervision immediately available in the first 365 days.

-Program Director, Family Medicine

VI.D.5.a).(1) This requirement should be modified or clarified to refer only to procedures or direct patient encounters. As written, it makes it impossible for a PGY-1 [specialty] resident to participate in laboratory consultations from home over the telephone. If the encounter is telephonic, the supervision should also be permitted to be telephonic, and PGY-1 residents should be permitted to participate in telephone consultations as call from home.

-Specialty Program Directors Association

I believe the intent of this section is to ensure that junior learners have someone who can reach them quickly if needed. In my system, clinical activities take place in multiple sites in close geographic proximity. In fact, a supervisor in the clinic building across the street may be more readily accessible to a learner than an individual on a different floor in the hospital. However, the wording of this section precludes this. To afford programs flexibility while still maintaining safe supervision, I would encourage the task force to consider altering the definition of “indirect supervision with direct supervision immediately available” from a physical location to a time - based reference (i.e. available within a certain time frame.) I would also strongly encourage the task force to extend the ability for a PGY 1 to advance to indirect supervision with direct supervision available with the achievement of a set of defined competencies to all programs. For some limited settings (i.e. ICUs) it would make sense to keep the “immediately available” standard for PGY 1s.

-Designated Institutional Official

Give the Pathology RC and the pathology programs more flexibility with the direct or indirect immediately convertible to direct rules for PGY1 residents in the second half of an academic year. Each resident learns at a different pace, and some are quite accomplished at some tasks by the end of 6 months. To continue to require the close supervision of all activities, including performance of autopsies, gross examination of surgical specimens (provided that the resident has been properly supervised and checked out on at least 3 iterations of examinations of each specimen type, done well in the eyes of the supervisor) is to put a burden on the programs (particularly smaller ones such as mine, 12 residents and 17 core faculty), and a limit on the residents, that in individual circumstances is unwarranted. Again, I won't make a general recommendation for all specialties but I suggest that allowing some flexibility if we document the abilities of the more outstanding PGY1 residents will benefit the residents and the programs and will not harm any patient, cause the loss of any specimen information, or put the resident at risk from fatigue or other danger. As you have no doubt heard before, graduated responsibility is a difficult aspiration in pathology residencies, given the thicket of regulations which prohibit billing of activities performed by residents when supervision is by oversight. Having residents able to progress to a certain degree of independence, to the level of at least indirect supervision with direct supervision available, would give a small advance in the kind of graduated responsibility we can give to our residents in this specialty. At least as we understand the current Pathology RC version of the rules, this is largely not possible.

-Program Director, Pathology

Requirement #: VI.E.

Requirement Language:

VI.E. Clinical Responsibilities

The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. (Core)

[Optimal clinical workload will be further specified by each Review Committee.]

List Individual Comment(s):

Perhaps VI.E should say responsibilities are based on program year, not PGY as there can be different PGYs in the same year of the program.

-Education Program Manager

Requirement #: VI.G. – VI.G.1.

Requirement Language:

VI.G. Resident Duty Hours

VI.G.1. Maximum Hours of Work per Week

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting. (Core)

List Individual Comment(s):

80 hours is still intense and if humane conditions are truly the goal then restricting to 60 with extended duration of training would make more sense. The overall number of hours is probably not as important as the work schedule. It is actually better I believe to have 2 hour shifts but fewer total shifts than to have twice as many 12 hour ones.

-Program Director, Family Medicine

We continue to support an 80 hour work week over 4 weeks. Most residents rarely meet the 80 hour limit in family medicine. However, in the instances where a resident comes close or exceeds, it is most commonly due to continuity of care needs for a critically ill patient or an obstetrical patient. Patient management, continuity of care, limitation of patient hand-offs and development of patient rapport are the elements that ultimately contribute to successful patient care and successful medical practices.

-Program Director, Family Medicine

The clinical practice of Emergency Medicine, as well as residency training in EM, lends itself inherently to comply with the ACGME 80-hour work week. Residents throughout all specialties are provided more detailed instruction in recognition and mitigation of impairment caused by fatigue by emphasizing duty hour monitoring and compliance. Benefits such as these are a direct result of the 80-hour work week, and cannot be overstated.

-Specialty Board

As a surgical educator, I would like to see residency programs have more flexibility in resident work schedules – specifically, not limiting residents to 80 hour work weeks. I feel that we have seen the effects of 80 hour workweeks (a change put in without clear evidence of its superiority). Now having experience with this system, I think that the ACGME should consider the potential benefits of a system that does not strictly limit resident work hours. With less

restrictive scheduling, surgical residents can provide greater continuity of care – even the best sign outs may miss critical details. Importantly, strict duty hour restrictions foster a shift worker mentality that does not foster the sense of accountability responsibility to the patient that it is critical to foster in developing young surgeons.

Thank you for considering my comments,

-Associate Professor of Surgery (Urology)

Requirement #: VI.G.1.a) – VI.G.1.a).(2)

Requirement Language:

VI.G.1.a) Duty Hour Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale. (Detail)

VI.G.1.a).(1) In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures. (Detail)

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO. (Detail)

List Individual Comment(s):

VI.G.1.a) We would do away with exceptions. If needed extend training.

-Program Director, Family Medicine

Remove the need to apply for and receive an exception for up to a 10% increase for surgical programs (VI.G.1.a). Instead, make it standard that surgical disciplines will have up to 88 hours.

-Specialty Program Directors Association

Consider removing VI.G.1.a)—is the duty hour exception needed anymore?

-Education Program Manager

Requirement #: VI.G.2. – VI.G.2.c)

Requirement Language:

VI.G.2. Moonlighting

VI.G.2.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. (Core)

VI.G.2.b) Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit. (Core)

VI.G.2.c) PGY-1 residents are not permitted to moonlight. (Core)

List Individual Comment(s):

VI.G.2.b) This severely restricts moonlighting which endangers rural hospitals that cannot get

residents to cover extended shifts of moonlighting. Many rural hospitals have 36 and 48 hours ER coverage shifts on the weekend where they likely average less than 1 patient per hour. It doesn't interfere with their appropriate rest since they typically get lots of sleep, but restricts their ability to make additional revenue, pay back student loans, and actually makes primary care and other lower paying specialties even more unfavorable for US medical students with high debt. Finally, we cannot restrict their off duty activities. They can fly to Vegas on a Friday evening after work and party, gamble, see shows all weekend and return Sunday night for duty on Monday morning. They easily are more fatigued and less prepared to do their duty after a 48 hour Vegas binge then they would be after 48 hours in a small, rural ER. As long as the faculty approve moonlighting and ensure the residents involved are able to do their regular duties, we should not be tracking and reducing their moonlighting opportunities in their off-duty time.

-Program Director, Family Medicine

Requirement #: VI.G.3.

Requirement Language:

VI.G.3. Mandatory Time Free of Duty

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)

List Individual Comment(s):

No change to the Common Program Requirements, but RRCs may wish to review the circumstances under which home call could occur during a scheduled day off.

-Designated Institutional Official

The duty hours FAQ outlines what is permitted during time off however this information is buried on the ACGME site. Would suggest examples of what may not be done on during the mandatory time off (e.g., documenting in the EHR).

Not sure if this needs to be called out somewhere or the most appropriate place, but should there be a recognition of increased EHR documentation, and access to patient records away from the clinical site, and the impact on duty hours and work-life balance?

-Director, Graduate Medical Education

"At home call cannot be assigned on these free days."

Specific comments on other program-related obligations on days off – semiannual meetings, mentorship meetings, didactics?

-Associate Dean for Graduate Medical Education

Requirement #: VI.G.4. – VI.G.4.a)

Requirement Language:

VI.G.4. Maximum Duty Period Length

VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration.
(Core)

List Individual Comment(s):

Thank you for inviting comments on the Orthopedic Surgery common program requirements edits for section VI. Overall, I feel the section is quite comprehensive and well organized. I am in agreement with most aspects of the provisions set forth in the document.

As the residency director, I have noticed a few inadequacies of the program as it relates to the PGY 1 class. The restrictions on this class are very limiting. I disagree with the 16 consecutive work limit as well as the provision restricting them from working overnight. As they are now required to be directly supervised at all times by a more senior level resident, they lose a considerable amount of education when they have to leave the hospital rather than staying overnight where many valuable learning experiences occur. This is still one of the few realms where there is more independent thinking and action by the resident (with phone call support by senior residents and attendings) but the intern loses out on these experiences.

Valuable skills like splinting, casting, insertion of traction pins, compartment pressure monitoring, as well as many others, would benefit the PGY 1 orthopedic resident as there are fewer opportunities with an overall limited 80 hour work week.

Please consider amending the restrictions on the PGY 1 class. In reality, they stayed far more consecutive hours as 4th year Sub-interns. Their restriction as a PGY is a regression in training.

-Program Director, Orthopaedic Surgery

Dear Committee:

I am writing in response to the request for input regarding Section VI of the common program requirements. I have been a program director for almost 10 years. During this time, we have had to change our entire curriculum in order to accommodate the requirement for PGY1s to have direct supervision and indirect with direct supervision immediately available. I believe this has caused the PGY1s to be delayed in assuming responsibility for patient care at the level of a physician, and we are not seeing an improvement in patient safety. The cleaning ladies at the hospital have more authority and responsibility than our interns do. We know our residents, we supervise them, and I believe they should be allowed to do more.

We have had to remove them from the nursing home because we cannot guarantee supervision there. This reduces the residents' opportunity for geriatric training. It reduces the chance for our nursing home patients to have excellent care. Please pull back on this requirement.

-Program Director, Family Medicine

I would like to see the 16 hour duty rule for interns changed back to a 24 hour rule. This would eliminate the need for our program to use a night float system which in my opinion is more taxing physically and mentally than 24 hour shifts. It would also eliminate one more patient handoff in a 24 hour period.

Ideally, It would be beneficial to allow the interns a 24 hour period where they are responsible for patient care followed by a 1 or 2 hour period to complete administrative tasks, do patient hand-offs, etc.

This would do much for the morale of the interns and allow them more days when they don't have any responsibilities to the program at all.

-Program Director, Family Medicine

VI.G.4.a) This is the worst part of the duty hours. 16 hours is not practical with 10 hour time off as that is a 26 hour clock. Just make it 14 if you are keeping the lower number. Ideally change this back to 24 plus 4 and therefore have fewer shifts. Perhaps the compromise is 24 hours plus 4 for follow-up but a minimum of 5 days off per 4 weeks.

-Program Director, Family Medicine

Asking the program to ensure and monitor effective, safe handoffs and to minimize the number of transitions in patient care is **disparate** when you restrict the interns to a 16 hour shift.

The following occurs when you enforce a 16 hour work restriction:

1. An excessive number of handoffs have to occur in order to cover the patient 24h per day leading to harm.
2. Residents are unable to have primary responsibility for their patients as they **don't get to see the results of the decisions** made earlier in the care of that patient. This leads to the senior being unable to take care of sick patient due to **less exposure to patient care** and we are ending up with senior residents that don't know what they are doing.
3. Multiple shift changes guarantees problems with transitions and although the 4:30 pm from days to long call may be robust, the transition from long call to night float at 8:00 is lacking in structure and is now second hand.
4. Shift work encourage the **shift mentality** and this may lead to lack of ownership of the patient and may prevent residents from taking an admission closer to their "check out" time.

We need to go back to interns being able to take a 24 hour call removing the arbitrary shift lengths that the work hour restrictions have created.

-Program Director, Internal Medicine

As a faculty we support eliminating the 2011 duty hour restrictions. We feel that the current 16 hour limitation for PGY-1 residents has limited learning time, minimized continuity experiences, increased patient hand-offs and increased resident fatigue by forcing programs to develop night float models.

-Program Director, Family Medicine

The work hour rules for interns is more onerous than it is for more senior residents. Namely they cannot work for more than 16 hours. This leads to added burden on the senior residents and additionally a night float system for the interns. I know that there is an ACGME study which is looking into this matter, whether work hour rules have translated to patient safety or better outcomes. The 16 hour rule for the interns is not liked by any of the residents including the interns. This should be looked into by the ACGME.

-Program Director, General Surgery

Remove the 16-hour maximum for PGY-1 residents (VI.G.4.a).

-Specialty Program Directors Association

The [Specialty College] believes that the current Duty Hours structure within the Common Program Requirements has created a culture where residents perceive themselves to be shift workers, thereby undermining the importance of continuity of patient care and professionalism, and diluting the residency experience.

Also, it has resulted in newly graduating residents who are grossly unprepared for the unrestricted responsibilities of an attending physician. We cannot continue to develop a workforce that expects to provide care in 8-12 hour increments. The [Specialty College] continues to support an 80-hour work week, averaged over four weeks.

We believe that the current 16-hour limitation for first year residents has restricted learning time, minimized continuity experiences, increased patient hand-offs and, paradoxically, increased resident fatigue. We recommend the adoption of Duty Hour limits that are commensurate with the level of training where PGY 1 resident are limited to a 24-hour shift plus one additional hour for continuity activities, and all other resident levels are permitted a six-hour

window following their 24-hour shift.

Furthermore, the [Specialty College] believes that completion of charting or paperwork should not be included in the total weekly Duty Hours. Physicians who are less efficient with their charting should not be encouraged to use valuable rotation or learning time to complete expected work requirements.

-Specialty College

VI.G.2.c), VI.G.4.a), and VI.G.5.a) PGY-1 residents are not permitted to moonlight, must not work more than 16 hours in duration, and should have 10 hours, but must have 8 hours in between shifts.

– These rules, along with the RC interpretation that PGY-1 residents cannot be on call, makes PGY-1 residents 16 hour, really 14 hour shift workers. During the PGY-1 year, it is crucial to develop a commitment to your patients that goes beyond working your duty shift. The shift mentality becomes very detrimental in the second and third years when they feel ‘put-out’ whenever patient responsibilities take more than the 14 hours they are used to working. It is damaging the physician-patient relationship which is crucial to high quality patient-centered medical care. Some specialties (like ER and hospitalists) fit very well with a shift coverage mentality, but most primary care and surgical specialties do not. Ingraining this mindset early leads to a lot of “un-teaching” in the subsequent years. I understand the sleep deprivation data and why the shift hours were set as they are, but when they are inexperienced early in their training, they have supervising residents and faculty directly available. Call, especially at-home call, would allow them to come to the hospital for quality learning experiences but not be stuck there for a 14 hour shift. We don’t use trackers on our residents to insure they stay in the hospital or office for their 14 hours, nor should we. I do not think PGY-1 residents should be able to moonlight, but they should be able to take call and manage their daily hours within the 80 hour weekly limit.

-Program Director, Family Medicine

The 16 hour limit on intern duty hours is unnecessarily obstructive to their learning and should be eliminated. There can be no longitudinal understanding of a patient’s progression through serious illness if you only have 16 hours on duty. Thank you.

-Program Director, Otolaryngology

Remove the 16-hour limit for interns.

-Designated Institutional Official

I wanted to write a short note about duty hours, section VI of the common program requirements. Our program was recently in the trial that allowed more flexibility for our trainees. While no system is perfect, allowing 24 hour shifts, especially for the junior residents made a definite difference for the better. This was seen in several ways, but specifically around night float. With less night float rotations, the residents were clearly more happy with their training and lifestyle, including better availability for day time teaching and more available time off on weekends. Even more importantly, the residents were happier but still provided better continuity of care for our busy, truly 24 hour, trauma and emergency surgery service.

I encourage the ACGME to consider these evidence based study conclusions as you consider your new rules.

-Program Director, Critical Care

We suggest that the common program requirements return to allowing the same scheduling guidelines for all trainees and eliminate these that advocate for shorter intern scheduling

timeframes. The current intern-specific requirements often force 1st year residents to have a schedule that is different to that of second year residents who are otherwise in the same duty pool of ‘junior’ residents. An unintended consequence is that having a different scheduling approach for interns can force a “shift” or “night float” schedule on only interns (simply to fulfill ACGME duty restrictions) that results in weeks of nighttime intern duty with limited direct educational opportunities by attending faculty in interactive and didactic lectures and other regular daytime learning activities most importantly regular morning ICU rounds. Indeed, we believe that the clinical material, multidisciplinary interactions and discussions that occur during multidisciplinary morning ICU rounds is the cornerstone of ICU education and demonstrates all adult learning principles, especially as relates to case-based and problem-based approaches. Such active educational opportunities should not be missed and now that the literature demonstrates no benefit to an approach that leads to the individuals missing such an opportunity, we suggest the ACGME focus at approaches that maximize educational value.

-Specialty Society

Requirement #: VI.G.4.b) – VI.G.4.b).(4).(b)

Requirement Language:

- VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. (Core)
- VI.G.4.b).(1) Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested. (Detail)
- VI.G.4.b).(2) It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours. (Core)
- VI.G.4.b).(3) Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty. (Core)
- VI.G.4.b).(4) In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. (Detail)
 - VI.G.4.b).(4).(a) Under those circumstances, the resident must:
 - VI.G.4.b).(4).(a).(i) appropriately hand over the care of all other patients to the team responsible for their continuing care; and, (Detail)

VI.G.4.b).(4).(a).(ii)

document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director. (Detail)

VI.G.4.b).(4).(b)

The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty. (Detail)

List Individual Comment(s):

VI.G.4.b).(1) Strategic napping being strongly suggested doesn't seem to really be necessary to put in as a detail requirement. (No one really has defined what "strategic napping" is.) Strongly recommending someone take a nap seems like it is outside of what should be in program requirements.

VI.G.4.b).(4) This entire section concerning unusual circumstances is a detail requirement. Since none of the requirements concerning documentation when a resident does stay past 24 hours are core requirements, how is this section effective as written? If the program does track this information as suggested, and a resident has done this more than deemed appropriate by the program-then what? There is no resolution in this section, nor is there any actual requirement. Suggest that VI.G.4.b).(4), and (i) and (ii) become core requirements, or the section should be removed. Same comment concerning VI.G.5.c).(1) and (a).

-Director, Graduate Medical Education

VI.G.4.b).(1) – "Strategic napping...is strongly suggested."

Is this too vague? Change to "encouraged"? This also points to the trainee – what about the support to do this from senior residents, attendings?

-Director, Graduate Medical Education

VI.G.4.b).(1) functionally very difficult to prescribe or mandate and so is largely a nonsensical standard. Should be removed or added only as an option for fatigue mitigation. These are minimum standards not a place for suggestions.

VI.G.4.b).(4) should be extended to first years as well. Residents lose valuable opportunities and non-residency attendings see this as terrible, leaving just as the important things are happening.

-Program Director, Family Medicine

It has been our experience and observations that residents working a night shift schedule (to meet the 16 hour rule) have been far more fatigued than our senior residents who work 24 hour shifts every 4th or 5th night. It is our opinion that residency training models should: support continuity of care for patients; encourage physicians to manage fatigue in a manner that will reflect professional call models; and support learning through role modeling. We believe that a graduated 24 hour call model will allow programs to regain these attributes. PGY1: 24 +1, PGY 2: 24 +2, PGY 3: 24+4.

-Program Director, Family Medicine

Section VI.G.4.b: revise the duty hour maximum of only 24 hours to allow residents to remain on duty the following day after call if they

- do not display any evidence of significant fatigue through a clearly delineated procedure (see our recommendations above at section VI.C),
- have access to and use alertness management strategies as delineated in requirement

VI.G.4.b.(1),

- engage in activities pertaining to documentation,
- engage in simulation labs or other scheduled educational activities that do not require patient contact, or
- meet the requirements delineated in section VI.G.4.b.(4) where an unusual circumstance arises where the resident remains to continue to provide care to a single patient.

-Specialty Program Directors Association

The 24+4 rule should be changed to 24+6, with no additional duties added for the 6-hour grace period. This change would allow all trainees more time to finish patient care duties and still attend rounds if desired.

-Designated Institutional Official

A validated ACGME curriculum in handoffs would standardize this process and allow for better resident preparation for handoffs when complying with work hour regulations. Hand offs are intimately related to resident work hour contentions as they may assist or hinder a resident's sense of patient ownership in an environment of multiple and recurrent daily patient care handoffs.

-Specialty Society

Thank you for taking the time to hear the voice of the customer, the resident and program director.

While the residents shouldn't be overworked as in the past, we need duty hour restrictions that better fit into the reasonable lifestyle. Some of the current duty hour restrictions are particularly onerous for the first year resident as well as the smaller programs.

The duty hour restrictions is frustrating for the residents as well as leadership in a small program. There are rotations that require longer hours and rotations that allow for shorter hours but this is not accounted for in the requirements as the duty hours are averaged over short periods over 1 month or 1 rotation not over longer times like months.

In addition, for a small program the 16 hour max for a PGY1 only ever gives the resident 1 day off per week at a time. It is very hard to get them a whole weekend off. This significantly impacts their lifestyle and satisfaction and recovery from a difficult job.

Also, 24 hours issue comes up as a violation frequently on weekends because of sign-out taking time and the need for effective hand offs. If 2 weekend teams work 24 hours, there needs to be some overlap for sign-out.

Thank you for listening.

-Program Director, Obstetrics and Gynecology

Requirement #: VI.G.5. – VI.G.5.a)

Requirement Language:

VI.G.5. Minimum Time Off between Scheduled Duty Periods

VI.G.5.a) PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods. (Core)

List Individual Comment(s):

VI.G.5.a) "Should" and "must" always seems hedgy and unnecessarily complicated for tracking, etc.

-Associate Dean for Graduate Medical Education

A point of clarification:

Resident A's shift is scheduled to end at 6pm.

Resident B's shift is scheduled to start at 6pm.

Resident A signs out the service to resident B from 6pm-6:30pm.

Does the calculation of time off between shifts for Resident A begin at 6pm (when the shift was scheduled to end) or at 6:30pm (when the resident has completed sign-out).

At our program, we've been using the second model for implementing Duty Hours.

However, it might be helpful if this frequently occurring scenario is explicitly addressed in the Program Requirements.

Thank you.

-Program Director, Obstetrics and Gynecology

As a Surgery Program Director, the single most common comment of graduates is that residency does not adequately prepare them for the time commitment of independent practice. Roughly a half of our graduates go onto fellowship and the other half into practice. Despite this difference, the comment is the same. While they feel technically solid and comfortable with patient care, they are not prepared to assume the inter- and intrapersonal interactions for their patients.

Their solution is not to alter the sum of 80 hours/week, but remove the other time constraints, i.e. duration of time off between duty periods and give them more autonomy over their own schedule. For example, if one service is done early, the resident is free to leave the hospital. If a new learning experience arises for that service, they could return without consequence. They also suggest that like many of our independent surgeons do, a brief visit with a patient you have taken care of, even when you are not on call or especially on a day that is "1 in 7 free" should be allowed. This establishes ownership and fosters the physician patient relationship called for by both patient and physician. At a time when care is being protocolized and parsed out to cross-coverage and non-physician providers, the simple personal presence of the primary operative physician is paramount to good care, and the way to prepare our graduates for the future - "the best way to care for your patients is to care about your patients."

Key in such changes remains in maintaining the current supervisory structure and process of progressive responsibility. The FIRST trial clearly supports these comments with benefit to resident education and experience and no harm to patients. Please extend "evidence based administration" to duty hours.

-Program Director, Surgery

I want to thank you for taking comments on this section.

I think we all understand the background for this section at this point. I also think that it has been the most difficult to adhere to when programs need to adjust due to complement size changes, absences, etc. I also think that many programs have had to contort their schedules to an increasing degree to adhere to some of the requirements. I also think that the ambiguity in some areas has led to excessive stress on the parts of trainees and programs themselves, partly due to the somewhat contradictory nature of what it is to be a physician and the lack of autonomy of the trainee inherent to such guidelines.

I find most problematic section VI.G.5. The language of "should" and "must" needs to be revised. If it is decided they need 8 hours, make it 8 hours. If they need 10, make it 10. Of course, recent evidence would seem to show that this requirement has no effect on proficiency or medical errors, so it may need to be deleted altogether! Trainees feel as though getting between 8-10 hours off is a violation (despite language to the contrary), even if it is for reasons

that meet criteria for section VI.G.4.b).(4). I feel that at times it negates the need to instill and support a professional attitude regarding primacy of the patient. I know that trainees always have the nagging worry about needing to get out of the hospital so they can come back after the 10 hour mark. They are adults; let's treat them as such.

Thank you.

-Program Director, Neurology

Section VI.G.5 (Minimum Time Off between Scheduled Duty Periods): consider making the requirement be a 10 hour period free of duty between assignments averaged over a month. This more accurately reflects practicing surgeons who will have periods where patient demands are high as well as other periods where demand is low.

-Specialty Program Directors Association

Clarification regarding the current duty hour rules of "PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods" and "Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods".

This should state 8 or 10 for both PGY1 and intermediate level residents. To include should have 10 and must have 8 is somewhat confusing at an institutional level and creates a problem for our residency management system (RMS). At [our clinic] we made a GMEC decision to must have 10 across the board, and set our RMS to flag any violation thereof, requiring the resident and Program Director to comment on any violation. Many programs feel it is their choice to decide between the 10 and 8-hour breaks.

We agree that the statement regarding the final years of education is appropriate, as residents will need to be prepared to work unsupervised in practice and care for patients over irregular timeframes.

-Accreditation Manager

Requirement #: VI.G.5.b)

Requirement Language:

VI.G.5.b) Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty. (Core)

List Individual Comment(s):

VI.G.5.b) Suggest changing to 12 hours off after 24 hours of duty as more functional for schedules and can still get home and get adequate sleep.

-Program Director, Family Medicine

Change the required 14-hour rest period after 24 continuous hours on duty to 12 hours and consider that the next shift must start on a next calendar day. This would allow more flexibility for beginning work at the start of a day.

-Designated Institutional Official

Requirement #: VI.G.5.c) – VI.G.5.c).(1).(a)

Requirement Language:

VI.G.5.c)	Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. (Outcome)
VI.G.5.c).(1)	This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. (Detail)
VI.G.5.c).(1).(a)	Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director. (Detail)

List Individual Comment(s):
 Thanks for the opportunity to comment on section VI. In general I think it is quite good. Under VI.G.5.c, though, what is missing is the concept of preparing residents to enter the practice of medicine and withstand the mental, emotional, and temporal stressors therein; in other words, to prepare them to manage the type of practice and workweek that they will encounter upon graduation. Many of the changes reflect protection of the residents during training but this concept of protection can extend after graduation—i.e., that we protect them from failing by preparing them for the aforementioned stressors.
-Program Director, Department of Ophthalmology

Requirement #: VI.G.6.
Requirement Language:
 VI.G.6. Maximum Frequency of In-House Night Float
 Residents must not be scheduled for more than six consecutive nights of night float. (Core)
 [The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

List Individual Comment(s):
 Please consider revising VI.G.6. It is not just a scheduling nightmare to introduce a new person for night float for 1 day of the week, but it selects a person whose diurnal rhythm is totally out of sync with the one night requirement to fill the gap, which likely introduces a safety risk to this behavior. It would be far better to change this to seven consecutive nights.
-Program Director, Radiology
 In most programs in the country, irrespective of what the program state, Night float is much more Service than Education. And, a small component of education, is at the expense of supervision which is less than in the daytime. If at all, the only advantage may be increased ability to make autonomous decisions which at times borders on compromised patient safety.
 For years, I, not unlike many program directors continued to fight the concept of Night floats. In present intern duty hour requirement, it is virtually impossible to run a residency program

without night float interns. I still have to find a night float intern who feels he/she got better education, more rest or less fatigue during night float. To the contrary, they miss out on multiple basic tenants of education in continuity of care, team building, teaching, or get taught.

-Program Director, General Surgery

I feel that there may be benefit to further clarification on the section describing night float.

Specifically—if during a 4 week clinical rotation, six 12-hour night shifts in a row occur, this is considered a night float rotation, correct?

If it is a night float rotation, how are the totals calculated for maximum allowed night float in any given year/residency? Do all four weeks of that rotation count towards total weeks of night float? Or just the total number of nights? (i.e. is it 6 days or 28 days in this instance?)?

-Associate Program Director, Surgery

Restrict the number of months during one year that a resident can be put on in-house night float.

-Designated Institutional Official

Requirement #: VI.G.7.

Requirement Language:

VI.G.7. Maximum In-House On-Call Frequency

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).
(Core)

List Individual Comment(s):

I would suggest improving guidance for “at home call” duty hours. What constitutes “at home” vs “in house” call? At what point, although the resident is on “at home call” should the “in house call” rules begin to apply (i.e. if a resident is in the house for more than 3 hours, 6 hours, 8 hours?).

Our residents greatly enjoy being able to go home when they can, but I get the sense of significant frustration with not having to abide by the “in house” call rules. It also creates confusion for our faculty who don’t know if they are supposed to send the resident home or keep them.

Perhaps a statement as simple as “residents should be instructed on and expected to monitor their fatigue and hand off care when too tired to care for patients while on at home call.”

-Associate Program Director, Orthopaedic Surgery

Requirement #: VI.G.8. – VI.G.8.b)

Requirement Language:

VI.G.8. At-Home Call

VI.G.8.a) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks. (Core)

VI.G.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)

VI.G.8.b) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period". (Detail)

List Individual Comment(s):

VI.G.8.a) Should define what type of work counts. If a resident goes to the hospital to do charting which could be done at home is this duty hours and so would reset the clock or count as duty hours or not. Some residents have tried this to get out of other work. Defining this would help a lot. Is charting at home duty hours work?

-Program Director, Family Medicine

VI.G.8 At-Home call

– This entire section is very confusing for residents. When they are working at the hospital during the day and then go on call at night, they do not understand the difference between working a continuous shift and being on-call. Often, they leave hand-off rounds at 6 pm and instead of going home until they get a call, they start with an admission right away. To them, they are still working so they struggle feeling the difference between a 24 hour shift and at-home call. While some institutions may require their residents to stay in the hospital for 24 hours, the majority either use a night float shift system or a home-call system. The requirements of length of shift are not really necessary. The total duty hours for the week and the frequency of any type of call or night float coverage should be fine. It could be written to a daily shift of 12-14 hours exclusive of call, with frequency of call restrictions and the total weekly hours. That would simplify matters significantly and make it much easier to comply.

-Program Director, Family Medicine

CPR VI.G:

- Requirements for working from home:
 - o From a practical standpoint, counting work from home causes issues because often times there are breaks (e.g., works after puts kids to bed, checks EMR to review cases the next day prior to going to bed). Not sure of the solution, but it seems the ACGME would want to encourage residents to balance home/work better and not have the program be penalized with a short break violation.
 - o It seems odd that if someone is on home call and they work from home (e.g., answering a call in the night), those hours do not count as work hours. However, if they are NOT on home call and go home and work (e.g., finish charts), the hours should be counted. Would be helpful to have consistency although this will also have repercussions!

-Education Program Manager

At [our clinic] there are a number of programs in which residents take at-home call that does not require them to come into the hospital while on call. These residents do however answer pages/phone calls, look-up patient information in the electronic medical record (EMR) and make medical decisions that do not require traveling into the hospital. We feel that this time should be recorded into the 80-hour workweek for the resident. For example, if 4 hours are spent working during an at-home call, the resident would record it as working hours in the RMS. This way the program would be able to determine if at-home call is taxing on the residents, as the time spent

on at-home call does count against the 1 day off in 7 duty hour rule, but no other rules. In addition, this would allow the program to determine if a resident should come in later the next day due to the time they were working during at-home call the day prior, so that they are well rested for their next shift. Currently the Duty Hour FAQs state “For call taken from home (home or pager call), the time the resident spends in the hospital after being called in counts toward the weekly duty hour limit;” there is no mention about the time that the resident works at-home.

-Accreditation Manager

Call for first-year residents: As applied to training in the specialty of Pathology, the prohibition against first-year residents taking call from home is counterproductive, primarily on educational grounds.

In the first place, pathology call is exclusively call from home, not in-house call. Thus the basic call experience in Pathology is different from the experience in the clinical specialties that gave rise to this prohibition. It is also fundamentally providing a consult service, not primary patient care, which again is a major distinction in the nature of the experience for the trainee.

Anatomic Pathology call is most likely to involve intra-operative consultation in which a pathology resident assists an attending. The pathology resident is thus acting under direct supervision and the encounter is highly educational. Clinical Pathology call is most likely to involve the resident in evaluating laboratory or blood bank issues that can be dealt with by telephone. Because it is home call, direct supervision in the strict sense is not possible, but conferring (also telephonically) with the resident’s supervisor prior to deciding upon a course of action is easy and again has substantial educational value. A program requirement that deprives Pathology residents of these educational call experiences for the entire first year of their training takes away from the resident’s experiences more than it adds.

In addition, some pathology residents train and eventually certify in only Anatomic Pathology or only Clinical Pathology. Their curricula are thus shorter by one year but are more focused in their subject matter. The program requirements for pathology acknowledge this difference by considering these residents to be in the final years of training sooner than residents in the combined Anatomic Pathology/Clinical Pathology 4-year track, and accordingly they are permitted to take on supervisory roles earlier in training. However, these AP-only and CP-only residents remain barred from taking call for the entire first year of their shorter three-year program. This fails to acknowledge their more rapid progress through training milestones and deprives them of an even larger proportion (one-third) of their possible educational call experiences.

The Program Directors Section also notes that the requirement that first-year residents not be assigned call is not explicitly stated in the program requirements. Nevertheless, it is mentioned in the Frequently Asked Questions, and programs are directly told that they may not have first-year residents on call or they will receive a citation from the Review Committee.

-Specialty Program Directors Association

My first recommendation is that the ACGME recognize that these rules ought not to be “one size fits all”, and by that I mean that there are fundamental differences between specialties, and the ACGME has not given the individual RCs sufficient flexibility with these rules. My specialty of Pathology has no in-house night call, and at most institutions the majority of calls during night-time on-call hours are for things which can be handled telephonically and do not require the presence of a physician-pathologist in the hospital. The restriction that first year residents cannot take call therefore makes sense from a supervision point of view for Clinical Pathology, which is the broad field in which most calls originate, since one can’t easily supervise a resident by telephone if he/she is at home. However, for the unusual situations in which a call is with regard to a task in Anatomic Pathology, be that an emergency autopsy (very rare indeed), or an

intraoperative consultation ("frozen section"), there is a great deal of educational benefit lost by barring first year residents from being "on call" for these procedures/events. The RC has allowed programs, with a wink and a smile, to define "call" rather tightly such as to allow PGY1 residents to carry a pager and to be called back, so long as they are still within a 16 hour "shift", for one of these types of AP tasks. This is semantic evasion, and does not set a reasonable example of honesty and professionalism. It would be more honest and not any great burden on a resident if he/she were "on call" for a night, at home, vulnerable to being called in for one of these AP tasks, especially since an attending would have to be present also and direct supervision would therefore be possible from the time that both individuals hit the hospital door. This might, on some occasions, actually be allowed to violate the 16 hour rules for PGY1 residents; since in Pathology residents rarely work over 60 hours per week and never, in my experience, approach 80 hours, there should be a way to eliminate the 16 hour rule as applied to pathology residents (whether the Radiology community feels the same about their specialty I can't say).

-Program Director, Pathology

General Comments:

It would be beyond beneficial to have a requirement for Program Attendings to have scheduled teaching time to Residents:

--> Hands on teaching techniques to Residents for improvement and perfection of everyday clinical procedures, documentation methods, insurance and billing knowledge, and more. Really, in general, having an organized program of teaching and training that leads Residents upward in a step wise fashion through all of the areas needed to become Independent Physicians within their specialty is what I am recommending here.

Here is my reasoning as to the above request/comment:

I am a First Year Resident and would consider the above to be of utmost benefit in becoming a qualified independent Physician. I presumed that this would have already been in place when becoming a Resident, but half way through the first year I have realized that it is not in place in any formal way, systematic, nor complete way. Much of the instruction currently in Residency is on a "as it crosses our path" basis, and only really when the Attending and Resident are in the same physical place at the same time and the issue teaching moment arises.

This is great, and needed ALSO. But, there should be more of a formal way of teaching to continue from Medical School upward.

I really think Residents would become far better in the end AND along the way if they were instructed step wise, formally, and corrected/refined along the way IN the specific setting of the topic.

(As opposed to ONLY in a lecture hall, at an unrelated time or setting without the ability to physically correct and refine the Resident's imperfections at a Procedure or in Documentation for example).

Finally, I realized that much of this may currently fall on the hands of an Upper Level Resident to whomever is a lower level Resident as far as teaching. However, far too much slips through the cracks this way with overburdened Upper Level Residents, and THEIR lack of commitment and understanding of that process to teach 100% to the Residents who are in levels below themselves)

Please, this needs to change. Those Attending Physicians that have decided to become the Teachers of a Residency should be the ones teaching and perfecting the development of Residents and it should be done in a Fail-Proof, Hands-On way.

Thank You,

-PGY-1 Resident, Family Medicine

I am responding to a request for suggestions to revise the common program requirements. I believe there will be other documents sent on behalf of the pediatric cardiology program directors. However, I would like to make one strong plea. I strongly urge that the language in the program requirements (and other ACGME documents such as WEB ADS) correctly differentiate between a “resident” and “fellow” and discontinue referring to a fellow as a resident. It becomes confusing, especially to faculty who are not as involved with these nuances. I imagine that the word “trainee” can be used if somethings applies to both types of trainees.

I thank you in advance.

Sincerely,

-Program Director, Pediatric Cardiology Fellowship

Please consider the following recommendations for the core requirements.

1. Teaching faculty should be allowed on inpatient to be preventive med, family practice if it is not to exceed 4 weeks a year. We are too restrictive to only allow general internists and subspecialists.
2. I would recommend that a cap of lower than 20 be suggested for new programs that do not have any upper level residents. I suggest it be 14 or 16. What we dealt with is administration noting that each intern would have to have up to 10 (20 total) without a resident as it is an ACGME requirement. If the attending does not see patients on their own (which detracts from teaching), 20 is too many for a two intern team to be safe and allow for good supervision. We took care of it by financing the difference to a 14 cap, but some hospitals don't do this.
3. Allowing SSEC up to 20% of faculty allowed who are board eligible and must have completed boards within 5 years.
4. Waive the scholarly activity requirements for community hospitals for subspecialists (too busy with their practice). This favors University Programs and is an impediment for new programs to develop due to costs related to having research infrastructure and payment to free up time for research in community hospitals.
5. Have a list of requirements for new programs that are exempt in the first 2 years of program defined.

Thank you for the consideration of these suggestions.

-Program Director, Internal Medicine

I hope the committee will consider moving SI specific requirements to the SI Institutional Requirements such as VI.A.1, VI. B.2., VI.B.4. , VI.C.3. It doesn't seem that they should be in the program requirements.

-Education Program Manager

Thank you in advance for the thoughtful approach to reviewing and revising the CPRs, and for this opportunity to give some input.

On a general level, I would encourage the task force to:

- 1) Strive for clarity of language and be very judicious with the must – should – strongly encourage continuum.
- 2) Strive for increased consistency across RRCs. Please limit the opportunities for RRC's to have multiple different permutations of the same requirement, particularly those which require institutional monitoring or oversight.
- 3) For those areas that do require program and or institutional monitoring and oversight, please be extra vigilant that the benefit to patient safety or learner welfare is

significant enough to justify the considerable cost of the monitoring process.

-Designated Institutional Official

Thank you for soliciting this input.

As a fellowship director, I feel very strongly that there needs to be more explicit wording allowing for leeway in duty hours with regards to fellows. Although language does exist that suggests flexibility, without specifics, most fellowship directors feel compelled to strictly adhere to the most literal interpretation of resident duty hours (the 16 hour shift limitation for interns being a notable exception). Fellows need to begin to have an "attending mindset" from day one of their advanced training, and program directors need specific guidelines that they can point to allow for less than 10 hours between shifts (for example, staying late after fellowship night float to complete a procedure, even if they need return by 7 PM), considering 22-23 hours a day off every so often, or other similar allowances. While the intention in the current iteration may be to allow for such things, few PDs feel that they can take that liberty.

-Program Director, Cardiology Fellowship

The common requirements are carefully constructed to be germane to ALL trainees.

However, there are vast differences between a PGY-5, 6, or 7 resident or fellow and PGY-1 intern. As well there are specialty differences (see below) The needs of such senior trainees periodically to own certain tasks that can span "duty periods" with greater flexibility and personal decisions are key elements of professionalism. Putting it another way, why is it ok for me to remain to finish the 20 hour heart case that has gone bad but my fellow (who is younger, equally committed, and needs/wants to see this through) must leave or face punishment for duty hour violations? Why can I remain post a shift to sit with a family when care is being withdrawn on their child, but my fellow must go home?

We have created a terrible conundrum in a bunch of specialties: lie about duty hours or tell the truth and get the program in trouble if trainees breach them, or else we must make trainees follow them and break their professional code of conduct.

We can do better. We need a flex allowance for the senior trainees. They also MUST have compensatory time off, but exactly when and how should be up to the trainee/program a bit more... albeit in line with safe rest science. So, for example right now, if a senior trainee in anesthesia stays until 11 pm with a case, I MUST leave them off the 7 am schedule for their 10 hours of rest. Once they arrive at 9 am next day, they can be expected to work a full day or even a late day. This stinks for the trainee and they hate same. So much better to say -MUST have 6-8 hour sleep break and if less than a full 10, then can work max of 5-6 hours next day provided there is a subsequent break which makes up or exceeds the minimum additive away time of 20 hours -...(home at 11 pm for a short night of sleep until 6 am then out at noon is far better than home at 11 pm, late morning in at 9 am but not home until 6 pm)

Hence, each RRC should be allowed to create a series of exceptions examples and rationales. I'd advocate then that each episode which breaks the rules requires completion of a simple exemption form where a couple of key questions get answered. And such are allowed sporadically in the senior years of training/monitored at site level.

Not everything in medicine can be handed off. Once I as a faculty am forced to do so, I will retire. My faculty involvement pact with a critically ill patient is I will see this particular event/episode through...

We need to stop pretending that this problem is present in all specialties, and we need to give the arenas that deal with death, procedures, critical care, emergency care some leeway in scheduling senior trainees. The reality is that their hours do suck more. Med students know this when they pick specialties. I really doubt this section of the program VI changes needs any senior trainee leeway for folks in areas like pathology, radiology, endocrine, dermatology,

ambulatory oriented practices, allergy/immunology, etc. But critical care, surgery, anesthesia, OB specialists take a crazy beating when they try to render continuity care in high stakes settings if their trainees are honest about some exceptional cases they cover/ don't want to hand over. Likewise for others when on these rotations.

I've seen these services at continual strained war with the DIOs. It needs to end. Some patients just do need continuity care. Someone needs to teach the senior trainees how it is done. Period.

Questionnaire should ask:

Was your extended shift due to an exceptional situation or case?

Was a handover mechanism possible but deemed not appropriate for the patient?

Were the hours made back up to you within the ensuing 48 hours in a manner that allowed you makeup rest?

Is the frequency of such situations rare?

When was your last hours breach?

Were you put in a position of being forced to remain beyond your ability to render safe care and be personally safe?

Would you handle this situation differently next time?

-Program Director, Pediatric Anesthesiology Fellowship

The duty hour requirements severely curtail academic program efforts to create an environment promotes professionalism or a sense of personal responsibility, and reduces the culture of patient safety in our residents. Section VI regulations create a culture where working hard is being seen as synonymous with being disrespectful to residents or dismissive of their need for time off. How are we encouraging professionalism with the Duty Hour regulations when they are being told that working longer hours is not acceptable? Older practitioners worked harder in their residency, had time off, felt as respected (or disrespected) as today's residents feel, and worked without the constraint of "mandatory duty hours".

Patient safety is compromised by repeat handoffs between different resident groups. Restricting hours necessitates increased hand offs between residents / fragmented care, and this cannot be seen as conducive to a culture of patient safety. The ACGME, however, pats itself on the back because, to accommodate for one poor set of regulations, they have introduced another poor set of regulations covering transitions of care. Amusing!

Micro-mandating the way all programs treat residents is fostering a culture where residents are being told that personal responsibility has no value. They are being subliminally told that unless supervisory bodies introduce regulations, program directors and faculty members will not do the right thing. This subliminal messaging does harm to everyone. Dr. Nasca and the ACGME should stop assuming that programs have no desire to take care of their residents, or wish to abuse residents. Individual cases of inappropriate treatment of residents will surface - social media is powerful. The marketplace of residency programs and social media will do a better job of creating good residency programs than will Dr. Nasca's duty hour regulations. ACGME, with its onerous set of regulations for everything, has taken individualism and innovation out of the system.

If we let our children determine how the house should be run, there will be chaos. The ACGME is creating a system where our kids use duty hour and the myriad complex of other residency related regulations as a cudgel against the programs and faculty. I hope that the ACGME recognizes that it has been barking up the wrong tree for years, and that it needs to cut programs and faculty more slack in letting them be the best judge of how to treat residents. ACGME must believe in the basic goodness of physicians and faculty members as it relates to the welfare of our residents. If we instead spend most of our time crossing the T's and dotting the I's, we are fostering a culture of bureaucratic maneuvering that does not do the house of

medicine any good. This is entirely similar to the entire CMS mandated quality initiative where physicians spend more time on meeting metrics, rather than taking care of patients!

-[Specialty and position unknown]

Dear Task Force.

I like the idea of this trial and the flexibility it allows to optimize resident education. So far the changes we have experimented with seem to be well received by the residents on our HPB service. It allows us to work their schedule around times when the best educational opportunities are available (clinics and OR).

I have heard only positive feedback from residents and faculty.

-Professor of Surgery

Dear ACGME:

In keeping with Daniel Pink's book Drive: The Surprising Truth About What Motivates Us, I think that all this attention to work hours has led to a change in culture and mentality of young physicians.

Instead of taking care of the patient, we are unintentionally making residents/physicians more aware about the "clock" than caring for the patient.

I am sending an article by Shanafelt looking at physician burnout.

- ED physicians seem to have the highest rate of burnout (replicated in many other papers)
- Neurosurgery has one of the lowest rate of burnout (replicated in many other papers)

Attending ED physicians have become the poster child of shift work. "No more than "X" 12 hour shifts in a week, no more than "x" consecutive shifts in a row, must get "x" hours of break in between, etc.."

They have a great work life balance.

Attending neurosurgeons have no work hour restrictions. I know plenty of neurosurgeons who start at 5 AM end at 8 PM M-F (sometimes Sat and Sun). There cases may go well into the night and get 2-4 hours of sleep. They have a terrible work life balance.

If the ACGME work hour policy was true, ED physicians would have the lowest burnout rate and neurosurgery would have the highest. Not so. Why?

One theory: ED focuses on the patient, but a secondary importance is the clock. I have had the ED program director call me when one of his residents rotating in OB is over 2 hours his/her allotted work hours. They bring up "fines" and "penalties" and "the world will come to an end" because a resident stayed extra to care for a patient. (Imagine that!!)

I can speak for myself but I would rather face the fine or penalty rather than have a resident/physician leave in the middle of a case to say "sorry, go to go my shift is done!"

Imagine if your parent, spouse, child needed care/surgery and the doctor left because of the "clock".

Daniel Pink brings up a great point. One profession that had seen a change for the worse are attorneys. When they went to charging everything by the minute/hour rather than the case or client, their professional and personal satisfaction went down. Mastery and purpose was not about the client or job, but the time!!

Maybe mastery and purpose should not be about the clock, but the patient!!

Just a thought.

-Program Director, Obstetrics and Gynecology

Thank you for giving us an opportunity to comment on Section VI of the Common Program Requirements.

My general perspective on this section is that it contains a number of excellent ideas but that some parts are too specific/arbitrary (e.g. PGY1 can only work 16 straight hours: Why not 17? Why not 15?) while others are sufficiently vague as to be difficult to operationalize or measure (e.g. “The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment”).

I recognize how extremely difficult the task of writing these guidelines is, but I think it is critical that we move away from arbitrary specifics while trying to minimize unmeasurable things such as being “committed.” We should instead move towards assessment of real circumstances. I think the ACGME survey is an especially valuable tool in this regard, and I think we need to use the tool to measure how often people are too tired or too overwhelmed to provide appropriate care, rather than worrying about how often they worked a particular number of hours or about what the program leadership is trying to accomplish.

I hope that is modestly helpful input. Thank you again for the opportunity.

-Program Director, Pediatrics

We support that completion of charting or paperwork is not to be included in the total weekly duty hours. Physicians who choose to be less efficient with their charting should not be encouraged to utilize valuable rotation or learning time to complete expected work requirements.

In an era where our patient population and current physician population is aging, the data continues to support the need for more primary care physicians. The demands will soon exceed the supply. We cannot continue to develop a workforce that expects to provide care in 8-12 hour increments.

-Program Director, Family Medicine

[Our] residents are faced with the same challenges as residents in other specialties when serving on off-service rotations outside of the [department] with respect to duty hour requirements. There has been an increase in the number of transitions of care; specialties that are not designed for shift work are now functioning in a similar manner to working shifts in a department, thus limiting continuity of care for the patient. Although there has been an increased focus on the hand-off process, these transitions make it difficult for the trainee to participate in the entire course of care for a single patient, and there is a commensurate loss of educational experience.

With regard to examination performance, [the Specialty Board] has studied the association of duty hours and scores on the initial Qualifying Examination. Over time, there has been no substantial change in examination performance associated with changes in duty hour requirements.

-Specialty Board

I am sure the task force is familiar with some of the new studies and the new patient safety data which demonstrates that resident duty hour restrictions have not made an impact on patient safety. While residents can make errors if they are fatigued, most resident errors are because they are residents in the midst of the learning curve. Thinking the duty hour restrictions would impact safety is foolhardy. Duty hours should be utilized to ensure residents have the best learning opportunities without being overly tired frequently. Instead residents are learning that they should never feel or be tired, and if they are they should call in sick or be allow to go home and sleep. We have had residents come in at midnight for a laboring patient, deliver by 4 am and request the entire next day off. No practicing physician would ever think that was appropriate after a busy call night. Some surgical studies have shown that physicians don't make mistakes the next day because they were up most of the night on call. That will change in

the future because we are training residents not to ever have to work under those conditions. We are creating a situation where the physician workforce will have to increase significantly to cover patient's needs and where much more learning will happen after residency training that needed to in the past. Giving programs flexibility to manipulate call, daily shifts, and night float coverages to ensure residents average 80 hours or less per week and a day off per week would be much more appealing. It would allow us to maintain the professional commitment to patients and still protect residents from excessive work.

-Program Director, Family Medicine

CPR VI.G:

- It would be helpful to integrate the information in the duty hours FAQs in here where possible (e.g., definition of work, averaging of hours depends on the length of the rotation).
- Possibly remove the “musts” and the “shoulds”—it makes sense conceptually and once understood is helpful, but confusing to those new to GME. Perhaps just say “must” or “must except in exceptional circumstances”. If keep both terms, perhaps define the terms in the requirements as most people will not look to the glossary for a definition.

-Education Program Manager

I am writing on behalf of our ACGME-accredited programs at [our university] in response to your request for feedback about Section VI of the Common Program Requirements (CPR). I have discussed these issues with our program directors and the members of our Graduate Medical Education Committee (GMEC). We have also reviewed the recently published results of the FIRST Trial and the information it provides about the impact of a more flexible schedule on the education and training environment. In response to these deliberations, we agree on the following principles and ask that you consider them as the CPR are revised:

- Oversight of the learning environment, and resident duty hours as a component part of that environment, is an important ACGME, institutional, and program responsibility. We commend ACGME for its effort in this area.
- Rigid duty hours rules are not specialty-specific nor do they prepare trainees for the reality of the practice environment in which they will work beyond residency. This may lead to unintended educational consequences without significant gains in patient safety. Many of our program directors emphasize the value of longitudinal involvement with patients as a critical part of professional development that is threatened by strict duty hours rules.
- As demonstrated in the FIRST Trial, a more flexible approach to duty hours may enhance education and resident well-being without increasing resident fatigue and negatively affecting patient safety. We strongly support this approach.
- Under the current CPR, the pressure to comply with duty hours ultimately falls to the residents themselves. This may increase resident stress and burnout during training as they strive to compress their work into well-defined shifts. Furthermore, social activities in the workplace, such as lunches and informal meetings with colleagues, can contribute to community-building and resilience. These may be de-emphasized in a restrictive duty hours environment.

In summary, our program directors and GME educational leadership support flexible limits on duty hours that mitigate resident fatigue while promoting educational opportunity and personal responsibility for fitness for duty. We appreciate ACGME's commitment to these principles and look forward to modifications of the CPR that promote this spirit.

-Designated Institutional Official

As the Program Director for the General Surgery Residency at [our university], I write in enthusiastic support for continuation of the relaxed duty hours as with the FIRST trial. While the relaxed restrictions have clearly decreased our duty hour violations (even in terms of 80 hours and “1 in 7” violations over prior years with the tighter restrictions), this is well beyond the administrative benefits in not having to track the non-evidence-based 16 hours and 24+4 restrictions. Our internal surveys over the last two years have shown clear and substantial improvements in resident satisfaction with duty hours and satisfaction with training in general. The residents are able to maintain patient continuity (including completing operations on their own patients) and stay longer, if they deem appropriate, to continue self-driven educational experiences. Additionally, we have been able to limit the months of night float rotations for the junior residents that require more frequent sign-outs and increased risk for data and patient issues being missed – clearly allowing for greater care continuity. There is also more “service to education” with night float rotations as there are understandably fewer faculty and senior residents around at night to teach than there are during the day. We have much less cross-coverage in the relaxed system, again improving resident satisfaction and patient care continuity (e.g., I no longer need a resident on one “lighter” rotation to cover a very busy service on a weekend night, not knowing any of the patients when they first come in). Finally, the residents are able to get more weekend days off, which they greatly covet (especially the “golden weekends”), as opposed to, for example, getting a Tuesday off in a shift system that is necessarily created in the more strict duty hours system. The faculty have also noted generally improved resident satisfaction, which in turn elevates their satisfaction and the general demeanor of the entire program. I have many residents already concerned about having to return to the previous restrictions, which is probably the best sign of all about their satisfaction with the relaxed duty hours. I sincerely hope that these can be preserved as we head into the 2016-2017 academic year, for the sake of the patients, the residents, and the administration. The relaxed duty hours’ restrictions allow us to train surgeons, not just shift workers.

-Program Director, General Surgery

I wholeheartedly support the modification/easing of resident duty hour restrictions. This will decrease the handoff-related patient care errors and shift-work mentality that are the hallmarks of the current system, and allow us to train more confident and capable surgeons within the allotted span of time.

-Professor of Surgery and Radiology

As you move forward with your deliberations for resident duty hours, I would like to encourage you to kindly consider the following important considerations for both resident satisfaction and patient safety.

- Improvements in resident satisfaction with duty hours and satisfaction with training in general.
- Better patient continuity (including completing operations on their own patients)
- Residents able to stay longer, if they deem appropriate, to continue self-driven educational experiences.
- Limited need for night float rotations for the junior residents that require more frequent sign-outs/increased risk for data and patient issues being missed – thus greater care continuity.
- More service to education with night float rotations with fewer faculty and senior residents at night to teach
- Less cross-coverage, again improving resident satisfaction and patient care continuity
- Better satisfaction with more weekend days off and “golden weekends” than with a shift system
- Many residents already concerned about having to return to the previous restrictions
- Decreased overall duty hour violations, not just 16 hours and 24+4 violations
- More focus on training surgeons instead of shift workers

-Associate Professor, Division of Cardiothoracic Surgery

I would urge a loosening of duty hours restrictions. They are disruptive of continuity of patient care. Many residents have expressed to me concerns about dilemmas caused by pitting a sense of duty in providing continuous patient care or a desire to stay and learn a new technique versus a sense of obligation to report hours and remain compliant. They want more freedom to do what they think is right.

I think interns still need some protection. Interns on a surgical service who are not categorical trainees and who are destined for other specialties are still at risk. However, senior residents and fellows are often older and more adept at managing the system and should be given more leeway.

-Chief, Section of Thoracic Surgery

I would like to add my voice to the strict restriction of resident hours.

The case has been well made that it does not improve patient care and as a chief of plastic reconstructive surgery, I can attest that loosening not tightening the hour restriction would improve resident training and ultimately improve patient care when the residents go into practice

-Chief, Division of Plastic and Reconstructive Surgery

The Program Directors Section is dismayed by the necessity of fitting [our specialty] into a model of training designed for the clinical specialties, when training in [our specialty] is so very different from training in the clinical specialties. [Our other] comments above are examples of how program requirements that may have great value in other specialties are counterproductive in [our specialty]. Above all, the Program Directors Section would like [our specialty] to have program requirements that are tailored to achieve optimal training in [our specialty] rather than having to create work-arounds to deal with requirements devised for other specialties.

-Specialty Program Directors Association

I am currently a Colon and Rectal surgeon at [our university]. I trained in the "old" system and in New York where the duty hours first changed and have lived through the growing pains of trying to create a good surgical education around the "80 hour work week". While I do not think that going back to a system of unlimited work hours is good, a system of "strict" duty hours with punitive threats has not been the answer either.

As a profession we lose all sense of "professionalism" when we stress to the residents that leaving an operative case to maintain the proper duty hours is more important than the completion of a case/care of the patient. It is a far better education for the resident and less erosive for the surgical "team" not to have the resident concentrating on the clock.

We have recently participated in the study of flexible hours and have found that the flexibility works far better than the prior shifts and night floats. There was less cross-coverage between services, less need for night float rotations for junior residents (who rarely saw attendings on the night shift making it a pure service rotation), more weekend days off and less duty hour violations.

While you continue to reevaluate the duty hour restrictions I have one plea. Please let us focus on training surgeons as professionals (ones that see the entire process through) and not shift workers who are worried more about when their shift is up.

-Professor, Colon and Rectal Surgery

We urge the Council to consider a more flexible house staff scheduling scheme particularly after release of the landmark FIRST study concluded: "As compared with standard duty-hour policies, flexible, less-restrictive duty-hour policies for surgical residents were associated with non-

inferior patient outcomes and no significant difference in residents' satisfaction with overall well-being and education quality. (FIRST ClinicalTrials.gov number, NCT02050789.)"

-Specialty Society

As a faculty in practice for last 20 years and having gone through the era of being in house call every other night (and at one point, being in house for two weeks straight!) to now folks playing tag with patient care, here are my thoughts in an abbreviated fashion:

1. If we want to keep attracting the best and the brightest, we need to have improvements in resident satisfaction with duty hours and satisfaction with training in general.
2. Outcomes are ever more important and everyone will soon be in Consumer Reports (perhaps even residents) - Better patient continuity is a necessary ingredient, including residents completing operations on their own patients.
3. The concept of residency grew from apprenticeship: Residents should be able to stay longer, if they deem appropriate, to continue self-driven educational experiences.
4. Limited need for night float rotations for the junior residents that require more frequent sign-outs/increased risk for data and patient issues being missed – thus greater care continuity.
5. More service to education with night float rotations with fewer faculty and senior residents at night to teach
6. Less cross-coverage, again improving resident satisfaction and patient care continuity
7. Better satisfaction with more weekend days off and “golden weekends” than with a shift system
8. Many residents already concerned about having to return to the previous restrictions
9. Decreased overall duty hour violations, not just 16 hours and 24+4 violations
10. More focus on training surgeons instead of shift workers; the shift mentality has really harmed the practice of medicine across the board. We have gone from one side of the pendulum clearly to the other.

Please help make it better for the future.

-Chief, Section of Pediatric Cardiothoracic Surgery

I would not advocate for any significant changes to the 80 hour limit, 1 day off in 7, or the current limitations on in-house call or burden of home call.

I would encourage the task force to either eliminate the specific requirements regarding short breaks or have a clear and consistent standard for length of break between duty periods for junior and intermediate residents of all specialties, and eliminate it for senior residents. Oversight and monitoring of this single requirement consumes an inordinate amount of time and energy, which appears to outweigh the benefit to our learners or patients. I believe that the other duty hour requirements provide a scheduling infrastructure that precludes extensive variation from this standard.

-Designated Institutional Official

Not Applicable Comments:

Would make one small change, which I think better aligns the continuous learning process with the common program requirements, rather than breaking up the goals and objectives by education year (or level).

IV.A.2. Competency-based goals and objectives for each assignment ~~at each educational level~~, which the program must distribute to residents and faculty at least annually, in either written or electronic form;

-Program Director, Dermatology

